

NEUROMUSCULAR AND REHABILITATION ASSOCIATES OF NORTHERN MICHIGAN

Patient: _____ Gender M F Birth date ____/____/____ AGE: _____

Marital Status: Single Married Widowed Divorced Minor *****IF A MINOR, ALSO COMPLETE REVERSE SIDE*****

Driver's License Number: _____ SS# _____

Street Address: _____ Home Phone: () _____

P.O. Box: _____ City: _____ Alternate Phone: () _____

State: _____ Zip: _____

Employer: _____ Work Phone: () _____

Employment Status: Full-time Part-time Retired Disabled Self Employed Unemployed Student

Spouse: _____ Birth date ____/____/____ SS# _____

Employer: _____ Work Phone: () _____

Employment Status: Full-time Part-time Retired Disabled Self Employed Unemployed Student

Insurance Information

****WE WILL MAKE COPIES OF ALL INSURANCE CARDS****

Primary Insurance: _____

Name of Subscriber: _____ Birth date ____/____/____ Relationship: _____

Secondary Insurance: _____

Name of Subscriber: _____ Birth date ____/____/____ Relationship: _____

Tertiary Insurance: _____

Name of Subscriber: _____ Birth date ____/____/____ Relationship: _____

Is this a worker's compensation claim? No Yes --- if yes, date of injury: _____ Claim# _____

Is this an auto claim? No Yes --- if yes, date of accident: _____ Claim# _____

Auto Carrier: _____ Address: _____

City, State, Zip: _____

I request that payment of authorized insurance benefits be made to DBMJ Rehabilitation Services, PLLC/Neuromuscular and Rehabilitation Associates of Northern Michigan on my behalf for any services furnished me, recognizing my responsibility for non-paid services. I authorize any holder of medical or other information about me to release to my insurance company or its agents any information needed to determine these benefits or benefits of related services.

I understand and agree that I am ultimately responsible for the balance of my account regardless of my insurance status. I accept responsibility for obtaining necessary referral forms, pre-certifications and/or second opinions for office visits or procedures. I will permit a copy of this authorization to be used in place of the original.

I consent to the use or disclosure of my protected health information by Neuromuscular and Rehabilitation Associates of Northern Michigan for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Neuromuscular and Rehabilitation Associates of Northern Michigan. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

SIGNATURE

DATE

****IF PATIENT IS A MINOR, COMPLETE THIS SECTION****

Who does the child live with: Mother & Father Mother Father Other (Please specify) _____

Father's Name: _____

Mother's Name: _____

Father's Birth date ____/____/____

Mother's Birth date ____/____/____

Father's SS# _____

Mother's SS# _____

Father's Employer: _____

Mother's Employer: _____

Father's work phone: _____

Mother's work phone: _____